		FOR OHF USE					

LL1

2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0037317

Facility Name: Lexington of Elmhurst

Address: 420 W. Butterfield Road (Number) Elmhurst (City) 60126 (Zip Code)

County: DuPage

Telephone Number: (630) 832-2300 **Fax #** (630) 832-7043

IDPA ID Number: 363682838001

Date of Initial License for Current Owners: 11/12/91

Type of Ownership:

[ ] VOLUNTARY,NON-PROFIT		[x] PROPRIETARY		[ ] GOVERNMENTAL	
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code		[ ]	Corporation	[ ]	Other
		[x]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: Charles J. Fischer **Telephone Number:** (312) 634-3400
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/02 to 12/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) _____
(Firm Name & Address) Altschuler, Melvoin and Glasser, LLP, One South Wacker Drive, Suite 800, Chicago, IL 60606
(Telephone) (312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 01/01/02 Ending: 12/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	150	Skilled (SNF)	150	54,750	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	150	TOTALS	150	54,750	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	17,505	6,047	6,202	29,754	8
9	SNF/PED					9
10	ICF	9,561	8,768	440	18,769	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	27,066	14,815	6,642	48,523	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.63%

D. How many bed-hold days during this year were paid by Public Aid?
14 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11/12/91

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date New construction NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 47 and days of care provided 6,029

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/02 Fiscal Year: 12/31/02

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst # 0037317 **Report Period Beginning:** 01/01/02 **Ending:** 12/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7**	8	9	10	
1	Dietary	279,709	29,504	8,901	318,114		318,114		318,114			1
2	Food Purchase		208,063		208,063		208,063	(10,062)	198,001			2
3	Housekeeping	210,820	28,414		239,234		239,234	516	239,750			3
4	Laundry	43,010	19,014		62,024		62,024	(4,535)	57,489			4
5	Heat and Other Utilities			171,877	171,877		171,877	2,757	174,634			5
6	Maintenance	64,269		84,066	148,335		148,335	950	149,285			6
7	Other (specify):*											7
8	**TOTAL General Services**	597,808	284,995	264,844	1,147,647		1,147,647	(10,374)	1,137,273			8
	B. Health Care and Programs											
9	Medical Director			17,750	17,750		17,750		17,750			9
10	Nursing and Medical Records	1,973,885	128,047	14,044	2,115,976		2,115,976		2,115,976			10
10a	Therapy			689,281	689,281		689,281		689,281			10a
11	Activities	156,732	10,346	3,384	170,462		170,462		170,462			11
12	Social Services	44,966		5,130	50,096		50,096		50,096			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,175,583	138,393	729,589	3,043,565		3,043,565		3,043,565			16
	C. General Administration											
17	Administrative	162,388		325,390	487,778		487,778	(325,390)	162,388			17
18	Directors Fees											18
19	Professional Services			49,077	49,077		49,077	(1,577)	47,500			19
20	Dues, Fees, Subscriptions & Promotions			16,342	16,342		16,342	1,372	17,714			20
21	Clerical & General Office Expenses	337,988	35,552	27,613	401,153		401,153	7,538	408,691			21
22	Employee Benefits & Payroll Taxes			399,700	399,700		399,700	49,644	449,344			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,271	2,271		2,271	2,164	4,435			24
25	Other Admin. Staff Transportation							7,098	7,098			25
26	Insurance-Prop.Liab.Malpractice			121,859	121,859		121,859	2,358	124,217			26
27	Other (specify):*											27
28	**TOTAL General Administration**	500,376	35,552	942,252	1,478,180		1,478,180	(256,793)	1,221,387			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,273,767	458,940	1,936,685	5,669,392		5,669,392	(267,167)	5,402,225			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

****See schedule of adjustments attached at end of cost report.**

Facility Name & ID Number Lexington of Elmhurst #0037317 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	D. Ownership											
30	Depreciation			29,460	29,460		29,460	136,909	166,369			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							265,420	265,420			32
33	Real Estate Taxes							69,630	69,630			33
34	Rent-Facility & Grounds			848,080	848,080		848,080	(848,080)				34
35	Rent-Equipment & Vehicles			4,054	4,054		4,054	3,260	7,314			35
36	Other (specify):*											36
37	**TOTAL Ownership**			881,594	881,594		881,594	(372,861)	508,733			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		132,991	30,423	163,414		163,414		163,414			39
40	Barber and Beauty Shops			31,781	31,781		31,781		31,781			40
41	Coffee and Gift Shops			195	195		195		195			41
42	Provider Participation Fee			82,125	82,125		82,125		82,125			42
43	Other (specify):* Nonallowable Costs			84,385	84,385		84,385	(84,385)				43
44	**TOTAL Special Cost Centers**		132,991	228,909	361,900		361,900	(84,385)	277,515			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,273,767	591,931	3,047,188	6,912,886		6,912,886	(724,413)	6,188,473			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

**** See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 01/01/02 Ending: 12/31/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(984)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(4,535)	4		8
9	Non-Straightline Depreciation	1,692	30		9
10	Interest and Other Investment Income	(872)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,330)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(62,959)	43		24
25	Fund Raising, Advertising and Promotional	(10,596)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(9,500)	43		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See attached Schedule A	(18,144)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (107,228)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(617,185)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (617,185)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (724,413)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington of Elmhurst

ID# 0037317

Report Period Beginning: 01/01/02

Ending: 12/31/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

Lexington Health Care Center of Elmhurst, Inc.
Provider # 0037317
1/1/02 - 12/31/02 **Schedule A**

Schedule VI. Adjustment detail
Line 29, Other

Description	Amount	Reference
Nonallowable collections	(8,779)	19
Miscellaneous income offset	(693)	21
Nonallowable miscellaneous expense	(8,863)	21
Deferred maintenance amort.	191	6
Total	(18,144)	

See Accountants' Compilation Report

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 01/01/02 Ending: 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(984)	0	0	0	0	0	0	0	0	0	0	(984)	2
3	Housekeeping	0	0	516	0	0	0	0	0	0	0	0	516	3
4	Laundry	(4,535)	0	0	0	0	0	0	0	0	0	0	(4,535)	4
5	Heat and Other Utilities	0	0	2,757	0	0	0	0	0	0	0	0	2,757	5
6	Maintenance	0	0	759	0	0	0	0	0	0	0	0	759	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(5,519)	0	4,032	0	0	0	0	0	0	0	0	(1,487)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	(325,390)	0	0	0	0	0	0	0	(325,390)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	50	7,152	0	0	0	0	0	0	0	0	7,202	19
20	Fees, Subscriptions & Promotions	0	0	1,372	0	0	0	0	0	0	0	0	1,372	20
21	Clerical & General Office Expenses	0	161	16,933	0	0	0	0	0	0	0	0	17,094	21
22	Employee Benefits & Payroll Taxes	0	0	40,566	0	0	0	0	0	0	0	0	40,566	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	2,164	0	0	0	0	0	0	0	0	2,164	24
25	Other Admin. Staff Transportation	0	0	0	7,098	0	0	0	0	0	0	0	7,098	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	2,358	0	0	0	0	0	0	0	2,358	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	211	68,187	(315,934)	0	0	0	0	0	0	0	(247,536)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(5,519)	211	72,219	(315,934)	0	0	0	0	0	0	0	(249,023)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lexington of Elmhurst # 0037317 **Report Period Beginning:** 01/01/02 **Ending:** 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	1,692	116,094	0	19,123	0	0	0	0	0	0	0	136,909	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(872)	263,198	0	3,094	0	0	0	0	0	0	0	265,420	32
33	Real Estate Taxes	0	68,080	0	1,550	0	0	0	0	0	0	0	69,630	33
34	Rent-Facility & Grounds	0	(848,080)	0	0	0	0	0	0	0	0	0	(848,080)	34
35	Rent-Equipment & Vehicles	0	0	0	3,260	0	0	0	0	0	0	0	3,260	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	820	(400,708)	0	27,027	0	0	0	0	0	0	0	(372,861)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(84,385)	0	0	0	0	0	0	0	0	0	0	(84,385)	43
44	**TOTAL Special Cost Centers**	(84,385)	0	0	0	0	0	0	0	0	0	0	(84,385)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(89,084)	(400,497)	72,219	(288,907)	0	0	0	0	0	0	0	(706,269)	45

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				Sambell of Elmhurst		
See attached Schedule B		See attached Schedule B		II Ltd. Ptsp.	Elmhurst	Real estate ptsp.
				Royal Mgmt. Corp.	Lombard	Mgmt. Co.
				Lexington Financial		
				Services II, L.L.C.	Lombard	Finance Co.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental expense	$ 848,080	Sambell of Elmhurst II Limited Partnership	**	$	$ (848,080)	1
2	V	19	Professional fees		Sambell of Elmhurst II Limited Partnership	**	50	50	2
3	V	21	Bank charges		Sambell of Elmhurst II Limited Partnership	**	50	50	3
4	V	21	Office supplies		Sambell of Elmhurst II Limited Partnership	**	111	111	4
5	V	30	Depreciation		Sambell of Elmhurst II Limited Partnership	**	116,094	116,094	5
6	V	32	Interest expense		Sambell of Elmhurst II Limited Partnership	**	260,769	260,769	6
7	V	32	Amortization of mortgage costs		Sambell of Elmhurst II Limited Partnership	**	2,429	2,429	7
8	V	33	Property taxes		Sambell of Elmhurst II Limited Partnership	**	68,080	68,080	8
9	V								9
10	V				** The owners of Lexington Health Care Center of Elmhurst, Inc. own 100%				10
11	V				of Sambell of Elmhurst II Limited Partnership				11
12	V								12
13	V								13
14	Total			$ 848,080			$ 447,583	$ * (400,497)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Elmhurst, Inc.
Provider # 0037317 **Schedule B**
1/1/02 - 12/31/02

VII. Related Parties
Owners

Name	Ownership %
James Samatas Discretionary Trust	16.66%
John Samatas Discretionary Trust	16.67%
Cynthia Thiem Discretionary Trust	16.67%
David S. Bell Revocable Trust	12.50%
Jeffrey J. Bell Revocable Trust	12.50%
Lawrence W. Bell Revocable Trust	12.50%
David S. Bell 2001 Trust	4.16%
Jeffrey J. Bell 2001 Trust	4.17%
Lawrence W. Bell 2001 Trust	4.17%

Name of facility	City
Lexington Health Care Center of Lombard, Inc.	Lombard
Lexington Health Care Center of Bloomingdale, Inc.	Bloomingdale
Lexington Health Care Center of Chicago Ridge, Inc.	Chicago Ridge
Lexington Health Care Center of LaGrange, Inc.	LaGrange
Lexington Health Care Center of Lake Zurich, Inc.	Lake Zurich
Lexington Health Care Center of Schaumburg, Inc.	Schaumburg
Lexington Health Care Center of Streamwood, Inc.	Streamwood
Lexington Health Care Center of Wheeling, Inc.	Wheeling
Lexington Health Care Center of Orland Park, Inc.	Orland Park

See Accountants' Compilation Report

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	Housekeeping supplies	$	Royal Management Corp.	**	$ 516	$ 516	15
16	V	5	Utilities - gas & electric		Royal Management Corp.	**	2,626	2,626	16
17	V	5	Utilities - water & sewer		Royal Management Corp.	**	131	131	17
18	V	6	Repairs & maintenance		Royal Management Corp.	**	715	715	18
19	V	6	Scavenger & exterminating		Royal Management Corp.	**	33	33	19
20	V	6	Security service		Royal Management Corp.	**	11	11	20
21	V	19	Computer consultant & supplies		Royal Management Corp.	**	5,698	5,698	21
22	V	19	Professional fees		Royal Management Corp.	**	1,454	1,454	22
23	V	20	Advertising - help wanted		Royal Management Corp.	**	825	825	23
24	V	20	Dues & subscriptions		Royal Management Corp.	**	547	547	24
25	V	21	Bank charges		Royal Management Corp.	**	1,901	1,901	25
26	V	21	Communications		Royal Management Corp.	**	380	380	26
27	V	21	Office supplies & printing		Royal Management Corp.	**	7,203	7,203	27
28	V	21	Postage		Royal Management Corp.	**	2,263	2,263	28
29	V	21	Telephone		Royal Management Corp.	**	5,186	5,186	29
30	V	22	FICA		Royal Management Corp.	**	21,866	21,866	30
31	V	22	FUTA		Royal Management Corp.	**	402	402	31
32	V	22	SUTA		Royal Management Corp.	**	438	438	32
33	V	22	Insurance - W/C		Royal Management Corp.	**	507	507	33
34	V	22	Insurance - hospitalization		Royal Management Corp.	**	12,719	12,719	34
35	V	22	401(k) and other emp. benefits		Royal Management Corp.	**	4,634	4,634	35
36	V	24	Travel & seminar		Royal Management Corp.	**	2,164	2,164	36
37	V								37
38	V		**Certain owners of Lexington Health Care Center of Elmhurst, Inc. own 100% of Royal Management Corp.						38
39	Total			$			$ 72,219	$ * 72,219	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	25	Auto expense	$	Royal Management Corp.	**	$ 7,098	$ 7,098	15
16	V	26	Insurance - general		Royal Management Corp.	**	2,358	2,358	16
17	V	30	Depreciation - vehicles		Royal Management Corp.	**	2,532	2,532	17
18	V	30	Depreciation - leasehold improv.		Royal Management Corp.	**	4,972	4,972	18
19	V	30	Depreciation - equipment		Royal Management Corp.	**	11,619	11,619	19
20	V	32	Interest		Royal Management Corp.	**	3,094	3,094	20
21	V	33	Property taxes		Royal Management Corp.	**	1,550	1,550	21
22	V	35	Equipment rental		Royal Management Corp.	**	3,260	3,260	22
23	V	17	Management fees	325,390	Royal Management Corp.	**		(325,390)	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V		**Certain owners of Lexington Health Care Center of Elmhurst, Inc. own 100% of Royal Management Corp.						38
39	Total			$ 325,390			$ 36,483	$ * (288,907)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	James Samatas	Owner/officer	Administrative	16.66%	See Schedule C	3	7%	Salary	$ 26,719	L 17, C 1	1
2	John Samatas	Owner/officer	Admin/Plant Ops	16.67%	See Schedule C	2	10%	Salary	11,875	L 17, C 1	2
3	Cynthia Thiem	Owner/officer	Administrative	16.67%	See Schedule C	2	10%	Salary	14,844	L 17, C 1	3
4	George Samatas	Officer	Administrative	0.00%	See Schedule C	2	10%	Salary	3,563	L 17, C 1	4
5	Jason Samatas	VP of Operations	Administrative	0.00%	See Schedule C	3	6%	Salary	8,998	L 17, C 1	5
6											6
7											7
8											8
9						All individuals work in excess of 40 hours per week.						9
10											10
11											11
12											12
13								TOTAL	$ 65,999		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Lexington Health Care Center of Elmhurst, Inc.
Provider # 0037317 **Schedule C**
1/1/02 - 12/31/02

VII. Related Parties
C. Statement of Compensation and Other Payments to Owners, Relatives and Members of the Board of Directors

5. Compensation Received From Other Nursing Homes

Name of facility	John Samatas	James Samatas	Cynthia Thiem	George Samatas	Jason Samatas	Total
Lexington Health Care Center of Bloomingdale, Inc.	13,617	30,638	17,021	4,085	10,318	75,679
Lexington Health Care Center of Chicago Ridge, Inc.	17,734	39,901	22,167	5,320	13,437	98,559
Lexington Health Care Center of LaGrange, Inc.	8,629	19,416	10,787	2,589	6,538	47,959
Lexington Health Care Center of Lake Zurich, Inc.	16,071	36,160	20,089	4,821	12,177	89,318
Lexington Health Care Center of Lombard, Inc.	17,734	39,901	22,167	5,320	13,437	98,559
Lexington Health Care Center of Orland Park, Inc.	21,376	48,096	26,721	6,413	16,194	118,800
Lexington Health Care Center of Schaumburg, Inc.	17,734	39,901	22,167	5,320	13,437	98,559
Lexington Health Care Center of Streamwood, Inc.	17,734	39,901	22,167	5,320	13,437	98,559
Lexington Health Care Center of Wheeling, Inc.	17,496	39,367	21,870	5,249	13,258	97,240
Total	148,125	333,281	185,156	44,437	112,233	823,232

See Accountants' Compilation Report

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Royal Management Corp.
Street Address: 665 W. North Avenue, Suite 500
City / State / Zip Code: Lombard, IL 60148
Phone Number: (630) 458-4700
Fax Number: (630) 458-4796

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	Housekeeping supplies	Bed Days	737,665	10	$ 6,954	$	54,750	$ 516	1
2	5	Utilities - gas & electric	Bed Days	737,665	10	35,380		54,750	2,626	2
3	5	Utilities - water & sewer	Bed Days	737,665	10	1,765		54,750	131	3
4	6	Repairs & maintenance	Bed Days	737,665	10	9,640		54,750	715	4
5	6	Scavenger & exterminating	Bed Days	737,665	10	438		54,750	33	5
6	6	Security service	Bed Days	737,665	10	150		54,750	11	6
7	19	Computer consultant & supplies	Bed Days	737,665	10	76,767		54,750	5,698	7
8	19	Professional fees	Bed Days	737,665	10	19,590		54,750	1,454	8
9	20	Advertising - help wanted	Bed Days	737,665	10	11,111		54,750	825	9
10	20	Dues & subscriptions	Bed Days	737,665	10	7,373		54,750	547	10
11	21	Bank charges	Bed Days	737,665	10	25,613		54,750	1,901	11
12	21	Communications	Bed Days	737,665	10	5,118		54,750	380	12
13	21	Office supplies & printing	Bed Days	737,665	10	97,051		54,750	7,203	13
14	21	Postage	Bed Days	737,665	10	30,484		54,750	2,263	14
15	21	Telephone	Bed Days	737,665	10	69,873		54,750	5,186	15
16	22	FICA	Bed Days	737,665	10	294,613		54,750	21,866	16
17	22	FUTA	Bed Days	737,665	10	5,419		54,750	402	17
18	22	SUTA	Bed Days	737,665	10	5,907		54,750	438	18
19	22	Insurance - W/C	Bed Days	737,665	10	6,829		54,750	507	19
20	22	Insurance - hospitalization	Bed Days	737,665	10	171,371		54,750	12,719	20
21	22	401(k) and other emp. benefits	Bed Days	737,665	10	62,427		54,750	4,634	21
22	24	Travel & seminar	Bed Days	737,665	10	29,161		54,750	2,164	22
23										23
24										24
25	TOTALS					$ 973,034	$		$ 72,219	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Royal Management Corp.
Street Address: 665 W. North Avenue, Suite 500
City / State / Zip Code: Lombard, IL 60148
Phone Number: (630) 458-4700
Fax Number: (630) 458-4796

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	25	Auto expense	Bed Days	737,665	10	$ 95,636	$	54,750	$ 7,098	1
2	26	Insurance - general	Bed Days	737,665	10	31,776		54,750	2,358	2
3	30	Depreciation - vehicles	Bed Days	737,665	10	34,112		54,750	2,532	3
4	30	Depreciation - leasehold improv.	Bed Days	737,665	10	66,995		54,750	4,972	4
5	30	Depreciation - equipment	Bed Days	737,665	10	156,541		54,750	11,619	5
6	32	Interest	Bed Days	737,665	10	41,692		54,750	3,094	6
7	33	Property taxes	Bed Days	737,665	10	20,881		54,750	1,550	7
8	35	Equipment rental	Bed Days	737,665	10	43,917		54,750	3,260	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 491,550	$		$ 36,483	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Lexington Financial Services,						$	$			$	1
2	L.L.C. II	x		Mortgage	$32,361.00	12/29/98	4,256,000	3,804,402	01/2008	0.0675	260,769	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$32,361.00		$ 4,256,000	$ 3,804,402			$ 260,769	9
	B. Non-Facility Related*											
10								Amortization of loan costs			2,429	10
11								Interest income offset			(872)	11
12								Allocated from management company			3,094	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 4,651	14
15	TOTALS (line 9+line14)						$ 4,256,000	$ 3,804,402			$ 265,420	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** N/A **Line #** N/A

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

SEE ACCOUNTANTS' COMPILATION REPORT

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2001 report.		$ 66,000	1
	Allocated from Management Company	1,550	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2001	$ 65,080	2
3. Under or (over) accrual (line 2 minus line 1).		$ 630	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 69,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 69,630	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	62,018	8
	1998	62,599	9
	1999	63,573	10
	2000	62,228	11
	2001	65,080	12

2001 taxes:	65,080
Estimated increase (6%):	1.06
Estimated 2002 taxes:	68,985
Use:	69,000

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lexington of Elmhurst COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0037317

CONTACT PERSON REGARDING THIS REPORT Susan Rojek

TELEPHONE (630) 458-4700 FAX #: (630) 458-4795

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not b entered in Column D. Do not include cost for any period other than calendar year 200l

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	06-14-317-008	Land and building	$ 65,080.04	$ 65,080.04
2.	Royal Management Corp. (Omni Partners)		$	$
3.	06-19-201-018	Land and building	$ 70,162.04	$ 108.00
4.	Royal Management Corp. (Samvest		$	$
5.	05-01-202-019	Land and building	$ 144,399.48	$ 1,441.00
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 279,641.56	$ 66,629.04

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services' _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill whic is normally paid during 2002.

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 01/01/02 Ending: 12/31/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 52,608 B. General Construction Type: Exterior Concrete Block Frame Steel Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [x] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [x] (a) Own the Equipment [x] (b) Rent equipment from a Related Organization. [x] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

Lexington Square Life Care of Elmhurst, Inc.; Continuing Care Retirement Community; 342 units; 485,300 square feet

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	55,000	1991	$ 1,277,670	1
2	Allocated from management company			12,084	2
3	TOTALS	55,000		$ 1,289,754	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	138		1991	1991	$ 4,110,586	$	35	$ 117,445	$ 117,445	$ 1,306,362	4
5	10		1995	1995	73,302	2,095	35	2,095		16,036	5
6	2		2001	2001							6
7											7
8											8
	Improvement Type**										
9	Building Improvement			1992	693	20	35	20		203	9
10	Land Improvement			1995	7,500	500	15	500		3,667	10
11	Fan Coil Units			1996	4,903	140	35	140		911	11
12	Patio			1996	2,322	155	15	155		1,006	12
13	Basement rehab			1997	17,151	1,715	10	1,715		9,290	13
14	Baseboards			1997	3,129	313	10	313		1,643	14
15	Wiring			1998	3,090	309	10	309		1,391	15
16	Lobby Tile			1999	19,354	1,935	10	1,935		7,580	16
17	Patio			1999	4,196	280	15	280		839	17
18	Automatic Door			2000	1,300	130	10	130		325	18
19	Wallpaper			2000	6,853	685	10	685		1,713	19
20	Patio			2000	1,242	83	15	83		207	20
21	Storage closet for HVAC			2000	3,745	250	15	250		624	21
22	Fire pump system			2001	4,141	414	10	414		621	22
23	Door releases			2001	4,420	442	10	442		663	23
24	Infrared curtains for elevators			2001	3,000	300	10	300		450	24
25	Parking lot			2002	2,532	253	10	253		253	25
26	Kitchen tile and plumbing			2002	9,661	664	10	664		664	26
27	Elevator upgrade			2002	2,595	216	5	216		216	27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Leasehold improvements - management company	1995	$ 7,659	$	35	$ 278	$ 278	$ 1,641	37
38	Leasehold improvements - management company	1996	6,233		35	226	226	1,158	38
39	Leasehold improvements - management company	1989	215		31	8	8	101	39
40	HVAC - management company	1998	161		35	6	6	23	40
41	Offices - management company	1999	407		35	15	15	41	41
42	Offices - management company	2000	193		35	7	7	15	42
43	Land improvements - management company	2002	7,248		15	443	443	443	43
44	Building - management company	2002	168,978		40	3,872	3,872	3,872	44
45	Sewer & water improvements - management company	2002	3,844		30	117	117	117	45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,480,653	$ 10,899		$ 133,316	$ 122,417	$ 1,362,075	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 125,256	$ 17,803	$ 18,144	$ 341	5 -10 years	$ 64,405	71
72	Current Year Purchases	21,155	758	758		5 years	21,154	72
73	Fully Depreciated Assets	262,007					262,007	73
74	Allocated from Management Company	116,043		11,619	11,619		30,353	74
75	TOTALS	$ 524,461	$ 18,561	$ 30,521	$ 11,960		$ 377,919	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79	Allocated from Management Company			22,663		2,532	2,532		15,770	79
80	TOTALS			$ 22,663	$	$ 2,532	$ 2,532		$ 15,770	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 6,317,531	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 29,460	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 166,369	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 136,909	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,755,764	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	Facility Rehabilitation	$ 213,391	92
93			93
94			94
95		$ 213,391	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 01/01/02 Ending: 12/31/02

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 7,314 Description: Postage Meter - $702; Copier - $3,352; Allocated from Management Company - $3,260
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L10A, C3	hrs	$	16,658	$ 256,524	$	16,658	$ 256,524	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		3,839	54,536		3,839	54,536	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		31,530	378,221		31,530	378,221	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				132,991		132,991	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See attached Schedule D					30,423			30,423	13
14	TOTAL			$	52,027	$ 719,704	$ 132,991	52,027	$ 852,695	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington of Elmhurst
Provider #: 0037317
01/01/02 to 12/31/02

Schedule D

XIV. Special Services (Direct Cost)
Line 13, Other

Service	Cost	Line Reference
Oxygen	18,901	L 39, C3
Laboratory	2,435	L 39, C3
Radiology	2,058	L 39, C3
Dentist	1,686	L 39, C3
Clinitron beds	5,343	L 39, C3
Total	30,423	

See Accountants' Compilation Report

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 01/01/02 Ending: 12/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 116,593	$ 127,547	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 441,532)	1,776,039	1,776,039	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	50,943	50,943	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	46,688	46,688	8
9	Other(specify): Escrow		32,520	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,990,263	$ 2,033,737	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	5,312	5,312	12
13	Land		1,289,754	13
14	Buildings, at Historical Cost		4,110,586	14
15	Leasehold Improvements, at Historical Cost	175,129	370,067	15
16	Equipment, at Historical Cost	137,424	547,124	16
17	Accumulated Depreciation (book methods)	(127,079)	(1,755,764)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (sp Construction in progr	213,391	213,391	22
23	Other(specify): Unamortized loan costs		38,871	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 404,177	$ 4,819,341	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,394,440	$ 6,853,078	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 321,007	$ 321,007	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	229,462	229,462	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	156,907	156,907	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,748	3,748	31
32	Accrued Real Estate Taxes(Sch.IX-B)		69,000	32
33	Accrued Interest Payable		21,400	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See attached Schedule E	166,535	85,891	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 877,659	$ 887,415	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,804,402	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 3,804,402	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 877,659	$ 4,691,817	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,516,781	$ 2,161,261	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,394,440	$ 6,853,078	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Lexington Health Care Center of Elmhurst, Inc.
Provider # 0037317
1/1/02 - 12/31/02 **Schedule E**

XV. Balance Sheet
C. Current Liabilities

36. Other Current Liabilities

Description	Operating	After Consolidation
Accrued Rent	80,644	-
Accrued management fees	22,704	22,704
Accrued 401 (k) contribution	7,518	7,518
401 (k) withholding	6,533	6,533
Due to related party	6,303	6,303
Other accrued expenses	42,833	42,833
Total line 36	166,535	85,891

XVII. Income Statement
E. Other Revenue

28. Other Revenue

Description	Amount
Investment in Lexington Financial Services, L.L.C. II	667
Miscellaneous income	693
Total line 28	1,360

See Accountants' Compilation Report

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,772,226	1
2	Restatements (describe):		2
3	**Prior period adjustment**	(75,361)	3
4	**Prior year's post closing entries**	(189,837)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,507,028	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,731,753	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(1,722,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 9,753	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,516,781	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,687,438	1
2	Discounts and Allowances for all Levels	(510,245)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,177,193	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,191,492	6
7	Oxygen	7	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,191,499	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	256	12
13	Barber and Beauty Care	37,317	13
14	Non-Patient Meals	984	14
15	Telephone, Television and Radio	84	15
16	Rental of Facility Space		16
17	Sale of Drugs	159,251	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	10,427	19
20	Radiology and X-Ray	2,502	20
21	Other Medical Services	58,359	21
22	Laundry	4,535	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 273,715	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	872	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 872	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**See attached Schedule E**	1,360	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,360	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,644,639	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,147,647	31
32	Health Care	3,043,565	32
33	General Administration	1,478,180	33
	B. Capital Expense		
34	Ownership	881,594	34
	C. Ancillary Expense		
35	Special Cost Centers	279,775	35
36	Provider Participation Fee	82,125	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,912,886	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,731,753	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,731,753	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. This entity files a cash basis tax return.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,003	2,063	$ 72,621	$ 35.20	1
2	Assistant Director of Nursing	3,361	3,765	100,583	26.72	2
3	Registered Nurses	28,894	30,979	759,017	24.50	3
4	Licensed Practical Nurses	9,373	9,940	209,774	21.10	4
5	Nurse Aides & Orderlies	64,214	67,149	743,656	11.07	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,154	6,664	88,234	13.24	8
9	Activity Director	702	702	9,400	13.39	9
10	Activity Assistants	15,184	15,908	147,332	9.26	10
11	Social Service Workers	2,916	2,916	44,966	15.42	11
12	Dietician					12
13	Food Service Supervisor	1,851	2,092	33,500	16.01	13
14	Head Cook	3,284	3,572	33,509	9.38	14
15	Cook Helpers/Assistants	15,769	16,872	146,408	8.68	15
16	Dishwashers	9,736	10,285	66,292	6.45	16
17	Maintenance Workers	3,649	3,959	64,269	16.23	17
18	Housekeepers	29,185	31,373	210,820	6.72	18
19	Laundry	6,643	6,959	43,010	6.18	19
20	Administrator	2,163	2,240	96,389	43.03	20
21	Assistant Administrator					21
22	Other Administrative	494	494	65,999	133.60	22
23	Office Manager					23
24	Clerical	17,363	18,998	337,988	17.79	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	222,938	236,930	$ 3,273,767 *	$ 13.82	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	152	$ 8,901	L 1, C 3	35
36	Medical Director	Monthly	17,750	L 9, C 3	36
37	Medical Records Consultant	21	1,025	L 10, C 3	37
38	Nurse Consultant	Monthly	480	L 10, C 3	38
39	Pharmacist Consultant	Monthly	1,200	L 10, C 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	12	3,384	L 11, C 3	44
45	Social Service Consultant	114	5,130	L 12, C 3	45
46	Other(specify)				46
47	Utilization review	4	720	L 10, C 3	47
48					48
49	TOTAL (lines 35 - 48)	303	$ 38,590		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	36	$ 720	L 10, C 3	50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	36	$ 720		53

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Mark Murphy	Administrator	0%	$ 96,389
John Samatas	Admin/Plant Ops	16.67	11,875
James Samatas	Administrative	16.66	26,719
Cynthia Thiem	Administrative	16.67	14,844
George Samatas	Administrative	0%	3,563
Jason Samatas	Administrative	0%	8,998
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 162,388

B. Administrative - Other

Description	Amount
Management fees (eliminated in column 7)	$ 325,390
TOTAL (agree to Schedule V, line 17, col. 3)	$ 325,390
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
ING	401(k) administration	$ 285
Altschuler, Melvoin & Glasser LLP	Accounting	14,023
American Express Tax & Bus Srv	Accounting	6,166
Systematic Management	Consulting	100
Freedman, Anselmo & Lindberg	Collections	8,779
Comprehensive Therapeutics	MDS Careplan Consulting	120
Personnel Planners	U/C Consulting	1,654
James Samatas	Legal	73
Internet Presence Consulting	Computer Consulting	711
Katten Muchin Zavis Rosenman	Legal	868
Carol Jeschke	Staffing Consultant	738
See attached Schedule F		15,560
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 49,077

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 59,354
Unemployment Compensation Insurance	30,177
FICA Taxes	244,908
Employee Health Insurance	86,640
Employee Meals	9,078
Illinois Municipal Retirement Fund (IMRF)*	
401(k) Contribution	12,152
Other Employee Benefits	7,035
TOTAL (agree to Schedule V, line 22, col.8)	$ 449,344

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 400
Advertising: Employee Recruitment	13,252
Health Care Worker Background Check	
(Indicate # of checks performed 25)	300
Miscellaneous dues & subscriptions	1,045
Miscellaneous licenses and permits	1,345
Allocated from Management Company	1,372
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 17,714

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,271
Allocated from Management Company	2,164
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,435

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Elmhurst, Inc.
Provider # 0037317
1/1/02 - 12/31/02 **Schedule F**

XIX. Support Schedules
C. Professional Services

Vendor/Payee	Type	Amount
Harris Kessler & Goldstein	Legal	4,178
Sachnoff & Weaver	Legal	6,579
Glantz-Richman	Rehabilitation Consultant	350
Answers on Demand	Computer Consulting	3,247
Action Computer Service	Computer Consulting	324
Gigatrend	Computer Consulting	195
Tri Com Computer Inc.	Computer Consulting	37
Information Controls, Inc.	Computer Consulting	650
Total, Other Professional Services		15,560
Total, Agrees to Schedule V, Line 19, Column 3		49,077
Allocated from management co.		
Altschuler, Melvoin & Glasser, LLP/		
American Express Tax & Business Services	Accounting	540
Brekke Consulting, Inc.	Exec. Counsel Consulting	125
Gilson, Labus and Silverman	Accounting	34
James Samatas	Legal	15
Katten, Muchin, Zavis and Rosenman	Legal	164
Sachnoff and Weaver	Legal	90
ING / Pension Administrators / Aetna Life Insurance & Annuity Co.	401 (k) Administration	402
Various	Consulting	5,782
Allocated from building partnership		
James Samatas	Filing and recording fees	50
Nonallowable legal fees		
Freedman, Anselmo, & Lindberg	Legal-collection fees	(8,779)
Total, Agrees to Schedule V, Line 19, Column 8		47,500

See accountants' compilation report.

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	Painting & decorating	12/99	$ 1,151	3 yrs	$ 192	$ 384	$ 384	$ 191	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 1,151		$ 192	$ 384	$ 384	$ 191	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 01/01/02 Ending: 12/31/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **No** If YES, have these costs
been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7.5 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **36,791** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? ____ YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES ____ NO **x** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **82,125**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classified
in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **No** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **9,078** Has any meal income been offset against
related costs? **Yes** Indicate the amount. $ **984**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **No** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such
transportation during this reporting period. $ N/A

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

RECONCILIATION REPORT **Lexington of Elmhurst** **03:21 PM** **11/04/05**

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-724,413	equal to	-724,413	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	265,420	equal to	265,420	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	69,630	equal to	69,630	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	166,369	equal to	166,369	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	7,314	equal to	7,314	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	689,281	equal to	689,281	0	O.K.	Pg16 Z12+Z14...	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- Supplies	132,991	equal to	#VALUE!	#VALUE!	#VALUE!	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	1,147,647	equal to	1,147,647	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	3,043,565	equal to	3,043,565	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	1,478,180	equal to	1,478,180	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	881,594	equal to	881,594	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	279,775	equal to	279,775	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+H	N/A	38to41+43	4
Income Stat. Prov. Partic.	82,125	equal to	82,125	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	1,885,651	equal to	1,973,885	-88,234	FAILED	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to		0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	156,732	equal to	156,732	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	44,966	equal to	44,966	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	279,709	equal to	279,709	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	64,269	equal to	64,269	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	210,820	equal to	210,820	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	43,010	equal to	43,010	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	162,388	equal to	162,388	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	337,988	equal to	337,988	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	3,273,767	equal to	3,273,767	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	8,901	< or = to	8,901	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	17,750	< or = to	17,750	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	3,425	< or = to	14,044	-10,619	O.K.	Pg20 X14..X16+	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	3,384	< or = to	3,384	0	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	5,130	< or = to	5,130	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	162,388	equal to	162,388	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	325,390	equal to	325,390	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	49,077	equal to	49,077	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	449,344	equal to	449,344	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	17,714	equal to	17,714	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	4,435	equal to	4,435	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	82,125	equal to	82,125	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	9,078	< or = to	49,644	-40,566	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	9,078	equal to	9,078	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	6,029	equal to	6,202	-173	FAILED	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	-617,185	equal to	-617,185	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4(	B.	14	8
Total loan balance	3,804,402	equal to	3,804,402	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	69,000	equal to	69,000	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	1,289,754	equal to	1,289,754	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	4,480,653	equal to	4,480,653	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	547,124	equal to	547,124	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	1,755,764	equal to	1,755,764	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	1,516,781	equal to	1,516,781	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	1,731,753	equal to	1,731,753	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	2,394,440	equal to	2,394,440	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustmen	Adjusted Total
1. Dietary	279,709	29,504	8,901	318,114	0	318,114	0	318,114
2. Food P	0	208,063	0	208,063	0	208,063	-10,062	198,001
3. Housek	210,820	28,414	0	239,234	0	239,234	516	239,750
4. Laundry	43,010	19,014	0	62,024	0	62,024	-4,535	57,489
5. Heat ar	0	0	171,877	171,877	0	171,877	2,757	174,634
6. Mainter	64,269	0	84,066	148,335	0	148,335	950	149,285
7. Other (s	0	0	0	0	0	0	0	0
8. Total G	597,808	284,995	264,844	1,147,647	0	1,147,647	-10,374	1,137,273
9. Medical	0	0	17,750	17,750	0	17,750	0	17,750
10. Nursin	1,973,885	128,047	14,044	2,115,976	0	2,115,976	0	2,115,976
10a. Ther	0	0	689,281	689,281	0	689,281	0	689,281
11. Activit	156,732	10,346	3,384	170,462	0	170,462	0	170,462
12. Social	44,966	0	5,130	50,096	0	50,096	0	50,096
13. Nurse	0	0	0	0	0	0	0	0
14. Progra	0	0	0	0	0	0	0	0
15. Other	0	0	0	0	0	0	0	0
16. Total H	2,175,583	138,393	729,589	3,043,565	0	3,043,565	0	3,043,565
17. Admin	162,388	0	325,390	487,778	0	487,778	-325,390	162,388
18. Direct	0	0	0	0	0	0	0	0
19. Profes	0	0	49,077	49,077	0	49,077	-1,577	47,500
20. Fees,	0	0	16,342	16,342	0	16,342	1,372	17,714
21. Clerica	337,988	35,552	27,613	401,153	0	401,153	7,538	408,691
22. Emplo	0	0	399,700	399,700	0	399,700	49,644	449,344
23. Inserv	0	0	0	0	0	0	0	0
24. Travel	0	0	2,271	2,271	0	2,271	2,164	4,435
25. Other	0	0	0	0	0	0	7,098	7,098
26. Insura	0	0	121,859	121,859	0	121,859	2,358	124,217
27. Other	0	0	0	0	0	0	0	0
28. Total (	500,376	35,552	942,252	1,478,180	0	1,478,180	-256,793	1,221,387
29. Total (	3,273,767	458,940	1,936,685	5,669,392	0	5,669,392	-267,167	5,402,225
30. Depre	0	0	29,460	29,460	0	29,460	136,909	166,369
31. Amorti	0	0	0	0	0	0	0	0
32. Interes	0	0	0	0	0	0	265,420	265,420
33. Real E	0	0	0	0	0	0	69,630	69,630
34. Rent -	0	0	848,080	848,080	0	848,080	-848,080	0
35. Rent -	0	0	4,054	4,054	0	4,054	3,260	7,314
36. Other	0	0	0	0	0	0	0	0
37. Total (	0	0	881,594	881,594	0	881,594	-372,861	508,733
38. Medica	0	0	0	0	0	0	0	0
39. Ancilla	0	132,991	30,423	163,414	0	163,414	0	163,414
40. Barbe	0	0	31,781	31,781	0	31,781	0	31,781
41. Coffee	0	0	195	195	0	195	0	195
42. Provid	0	0	82,125	82,125	0	82,125	0	82,125
43. Other	0	0	84,385	84,385	0	84,385	-84,385	0
44. Total S	0	132,991	228,909	361,900	0	361,900	-84,385	277,515
45. Grand	3,273,767	591,931	3,047,188	6,912,886	0	6,912,886	-724,413	6,188,473

	Operating	After Consolidation
General Service Cost Center		
1. Cash on	116,593	127,547
2. Cash - F	0	0
3. Account	1,776,039	1,776,039
4. Supply I	0	0
5. Short-Te	0	0
6. Prepaid	50,943	50,943
7. Other Pr	0	0
8. Account	46,688	46,688
9. Other (s	0	32,520
10. Total c	1,990,263	2,033,737
LONG TERM ASSETS		
11. Long-T	0	0
12. Long-T	5,312	5,312
13. Land	0	1,289,754
14. Buildin	0	4,110,586
15. Leaseh	175,129	370,067
16. Equipn	137,424	547,124
17. Accum	-127,079	-1,755,764
18. Deferre	0	0
19. Organi	0	0
20. Accum	0	0
21. Restric	0	0
22. Other l	213,391	213,391
23. other (s	0	38,871
24. Total L	404,177	4,819,341
25. Total A	2,394,440	6,853,078
CURRENT LIABILITIES		
26. Accour	321,007	321,007
27. Officer'	0	0
28. Accour	229,462	229,462
29. Short-T	0	0
30. Accrue	156,907	156,907
31. Accrue	3,748	3,748
32. Accrue	0	69,000
33. Accrue	0	21,400
34. Deferre	0	0
35. Federa	0	0
36. Other (	166,535	85,891
37. Other (	0	0
38. Total C	877,659	887,415
LONG TERM LIABILITES		
39.Long-Te	0	0
40.Mortgag	0	3,804,402
41.Bonds I	0	0
42.Deferre	0	0
43.Other L	0	0
44.Other L	0	0
45.Total Lo	0	3,804,402
46.Total Li	877,659	4,691,817
47.Total Eo	1,516,781	2,161,261
48.Total Li	2,394,440	6,853,078

		Balance per Medicaid Trial Balance
1.	Gross F	7,687,438
2.	Discour	-510,245
	Subtota	7,177,193
4.	Day Ca	0
5.	Other C	0
6.	Therap	1,191,492
7.	Oxygen	7
	Subtota	1,191,499
9.	Paymer	0
10.	Other	0
11.	Nurse	0
12.	Gift an	256
13.	Barbe	37,317
14.	Non-P	984
15.	Teleph	84
16.	Rental	0
17.	Sale o	159,251
18.	Sale o	0
19.	Labora	10,427
20.	Radiol	2,502
21.	Other	58,359
22.	Laund	4,535
	Subtot	273,715
24.	Contril	0
25.	Interes	872
	Subtot	872
27.	Other	1,360
28.	Other	0
	Subtot	1,360
30.	Total F	8,644,639
31.	Gener	1,147,647
32.	Health	3,043,565
33.	Gener	1,478,180
34.	Owner	881,594
35.	Specia	279,775
35.	Provid	82,125
37.	Other	0
40.	Total E	6,912,886
41.	Incom	1,731,753
42.	Incom	0
43.	Net In	1,731,753

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Line 16 for mortgage insurance.